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RULE AND REGULATION 18

MINIMUM STANDARDS FOR DISABILITY INSURANCE

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Section 1. Purpose

The purpose of this rule is to implement Ark. Stat. Ann. §66-3603 and Ark. Stat. Ann. §66-4721 and §66-5221, so as to provide reasonable standardization and simplification of terms and coverages of individual disability insurance policies, individual subscriber contracts of hospital, medical and dental service corporations and health maintenance organizations and certificates of fraternal benefit societies in order to facilitate public understanding and comparison and to eliminate provisions contained in individual disability insurance policies and individual subscriber contracts of hospital, medical, and dental service corporations, and health maintenance organizations and certificates of fraternal benefit societies, all of which are hereinafter referred to as "Policy" or "Policies", which may be misleading or confusing in connection either with the purchase of such coverages or with settlement of claims and to provide for full disclosure in the sale of such coverages.

Section 2. Authority

This rule is issued pursuant to the authority vested in the Commissioner under Ark. Stat. Ann. §66-2111, §66-3001 through §66-3028, §66-3210, §66-3603, §66-4744, §66-4920, and §66-5221.

Section 3. Applicability and Scope

This rule shall apply to all Policies delivered or issued for delivery in this State on or after the effective date hereof, except it shall not apply to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this rule, nor to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this rule. This rule does not apply to Individual Credit Disability Policies nor to Medicare Supplement Policies.

Section 4. Effective Date

The provisions of this rule shall become applicable August 1, 1987.

Section 5. Definitions

Except as provided hereafter, no Policy or Policies delivered or issued for delivery to any person in this State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section.

A. "One period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days.

B. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditations by the Joint Commission on Accreditation of Hospitals.

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(a) be an institution operated pursuant to law; and

(b) be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

(c) provide 24 hour nursing service by or under the supervision of registered graduate professional nurses (RNs).

(2) The definition of the term "hospital" may state that such term shall not be inclusive of:

(a) convalescent homes, convalescent, rest or nursing facilities; or

(b) facilities primarily affording custodial, educational or rehabilitory care; or

(c) facilities for the aged, drug addicts or alcoholics; or

(d) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services; or

(e) any facility, contracted for or operated by any state, county or local government, or any agency thereof in which the insured is furnished services for which, in the absence of insurance, he would not be required to pay.

C. "Convalescent Nursing Home", "Extended Care Facility", "Skilled Nursing Facility", or substantially similar terms, may be defined in relation to its status, facilities, and available services. Rehabilitatory facilities are licensed as hospitals in Arkansas but shall be included in the definition of convalescent nursing homes for the purposes of this rule.

(1) A definition of such home or facility shall not be more restrictive than one requiring that it:

(a) be operated pursuant to law;

(b) be approved for Payment of Medicare benefits or be qualified to receive such approval, if so requested;

(c) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(d) provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.) for at least 8 hours per day and a registered graduate professional nurse (R.N.) or licensed practical nurse (L.P.N.) for the remaining 16 hours; and

(e) maintains a daily medical record of each patient.

(2) The definition of such home or facility may provide that such term shall not be inclusive of:

(a) any home, facility or part thereof used primarily for rest;

(b) a home or facility for the aged or for the care of drug addicts or alcoholics; or

(c) 'a home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

D. "Accident", "Accidental Injury", "Accidental Means", may be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which is the direct cause, independent of disease or bodily infirmity or any other cause and occurs while the insurance is in force.

Such definition may provide that injuries shall not include injuries for which benefits are provided under worker's compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

Note: The first party coverage which was prescribed for use in automobile liability policies issued in Arkansas effective July 1, 1974, is not a motor vehicle no-fault plan under which benefits may be excluded under this Section.

E. "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any worker's compensation, occupational disease, employer's liability or similar law.

F. "Pre-existing condition" shall not be defined to be more restrictive than the following: Pre-existing condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five (5) year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five (5) year period preceding the effective date of the coverage of the insured person.

G. "Physician" may be defined by including, such words as "duly qualified physician" or "duly licensed physician". The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

H. "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as a registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed psychiatric technician nurse (L.P.T.N.). If the words "nurse", "trained nurse", or if registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

"Total Disability"

(1) A general definition of total disability shall not be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training or experience and not in fact engaged in any employment or occupation for wage or profit.

(2) Total disability may be defined in relation to the inability of the person to perform duties but shall not be based solely upon an individual's inability to: (a) Perform "any occupation whatsoever", “any occupational duty", or "any and every duty of his occupation", or (b) Engage in any training or rehabilitation program.

(3) An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of ones regular occupation or words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

J. "Partial Disability" may be defined in relation to the individual's inability to perform one or more but not all of the "major", "important", or "essential" duties of employment or occupation or may be related to a "percentage" of the time worked or to a "specified number of hours" or to "compensation". Where a Policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

K. "Residual Disability" may be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major", "important", or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A Policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability", the insurer may use "proportionate disability", or other terms of similar import which in the opinion of the Commissioner adequately and fairly describes the benefit.

L. "Medicare" may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Laws 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act", as then constituted and any later amendments or substitutes thereof or words of similar import.

M. "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Section 6. Prohibited Policy Provisions

A. Except as provided in Section 5(E), no Policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy

may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six (6) months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

B. No Policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six (6) months.

The initial renewal subsequent to the issuance of any Policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.

C. No Policy shall exclude coverage for a loss due to a pre-existing condition for a period greater than twelve (12) months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such pre-existing condition is not specifically excluded by the terms of the Policy.

D. A disability income policy may contain a "return of premium" or "cash value benefit" so long as: (1) such return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the Policy; (2) the insurer demonstrates that the reserve basis for such Policies is adequate; and (3) the Policy guarantees that it is renewable. No other Policy shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during .disability, payment of dividends on participating policies, or experience rating refunds.

E. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding or reducing coverage, because of confinement in a hospital contracted for or operated by the federal, state, county or local government.

F. No Policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

(1) pre-existing conditions or diseases, except for congenital anomalies of a covered dependent child;

(2) mental or emotional disorders, alcoholism and drug addiction;

(3) pregnancy, except for complications of pregnancy, other than for Policies defined in Section 7(F) of this rule;

(4) illness, treatment or medical condition arising out of:

(i) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or unites auxiliary thereto;
(ii) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
(iii) aviation, except as a fare paying passenger on a scheduled aircraft;
(iv) interscholastic sports, with respect to short-term nonrenewable policies.

(5) cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

(6) treatment provided in a government hospital, except as provided in Section 5(B)(2)(d) or 5(B)(2)(e)*;* benefits provided under Medicare or other government program (except Medicaid), any state or federal worker's compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered

by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and any other services for which no charge is normally made in the absence of insurance;

[Note: The first party coverage which was prescribed for use in automobile liability policies issued in Arkansas effective July 1, 1974,is not a motor vehicle no-fault plan under which benefits may be excluded under this Section.]

[Note: Hospital confinement indemnity coverage shall be controlled by Section 6(E) and not 6(F).]

(7) dental care or treatment; except that "dental care" or "treatment" shall not include reconstructive surgery when such service is incidental to trauma;

(8) eye glasses, hearing aids and examination for the prescription or fitting thereof;

(9) rest cures, custodial care, transportation and routine physical examinations; and

(10) territorial limitations.

G. Provisions of this rule shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required, unless on the initial issuance of the Policy the full text of the waiver is contained or referred to either on the first page or specification page.

Section 7. Disability Minimum Standards for Benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual Policy shall be delivered or issued for delivery in this State which does not meet the required minimum standards for the specified categories unless the Commissioner finds that such policies or contracts are approvable as Limited Benefit Health Insurance and the Outline of Coverage complies with the appropriate outline in Section 9(J) of this rule.

Nothing in this section shall preclude the issuance of any Policy or contract combining two or more categories of coverage.

A. General Rules

(1) Each Policy shall contain on its face page the actual title or titles reflecting the categories contained in Section 7.

(2) A "noncancellable", "guaranteed renewable", or "noncancellable and guaranteed renewable" Policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than non-payment of premium. The Policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the Policy, shall become the insured.

(3) The terms "noncancellable", "guaranteed renewable", or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 8(A)(1). The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the Policy until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the Policy while the Policy is in force; provided, however, any disability Policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue

the Policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the Policy in force at least to age sixty-five (65) while actively or regularly employed. Except as provided above, the term "guaranteed renewable" may be used only in a Policy which the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the Policy while the Policy is in force, except that the insurer may make changes in premium rates by classes; provided, however, any disability Policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the Policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the Policy in force at least to age sixty-five (65) while actively and regularly employed.

(4) In a family Policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable, or "guaranteed renewable". However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the Policy may be continued in force as to the younger spouse to the age or for the durational period as specified in said contract.

(5) When accidental death and dismemberment is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.

(6) If a Policy contains a status type military service exclusion or a provision which suspends coverage during military service, the Policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro-rata basis.

(7) In the event the insurer cancels or refuses to renew, Policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the Policy is in force and for which benefits would have been payable had the Policy remained in force.

(8) Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.

(9) Family coverage shall continue for any unmarried dependent child who is incapable of self sustaining employment due to mental retardation or physical handicap, on the date that such child's coverage would otherwise terminate under the Policy due to the attainment of a specified age limit (prior to the attainment of 19) for children and is chiefly dependent on the insured for support and maintenance. The coverage shall continue so long as the contract remains in force and so long as the dependent remains in such condition. Notice of such incapacity or dependency must be furnished to the insurer by the policyholder except in no event shall this notice requirement preclude eligible dependents under this regulation regardless of age.

(10) Any Policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's Policy, after benefits for the recipient's own expenses have been paid.

(11) A Policy may contain a provision relating to recurrent disabilities provided; however, that no such provision shall specify that a recurrent disability be separated by a period greater than six (6) months.

(12) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. However, no claim shall be denied wherein the insured with the use of extraordinary life support systems delays the loss for more than ninety (90) days from the date of the accident. Disability income benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any Policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the Policy was in force.

(13) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(14) Any accident only Policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the Policy.

(15) Termination of the Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period the Policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits.

(16) If, to prevent overinsurance, benefits are reduced due to the presence of Medicare, then benefits may be reduced for those insureds actually covered by Medicare. Benefits may not be reduced based solely on eligibility for Medicare.

B. Basic Hospital Expense Coverage

"Basic Hospital Expense Coverage" is a Policy of disability insurance which provides coverage for a period of not less than thirty-one (31) days during any continuous hospital confinement for each person insured under the Policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

(1) daily hospital room and board in an amount not less than the lesser of (a) 80% of the charges for semi-private room accommodations or (b) $80.00 per day;

(2) miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than 80% of the charges incurred up to a maximum of at least $5,000.00 or thirty-one (31) times the daily hospital room and board benefits, whichever is the lesser; and

(3) hospital out-patient services consisting of (a) hospital services on the day surgery is performed, and (b) hospital services rendered within seventy-two (72) hours after accidental injury, in an amount not less than $80.00, and (c) x-ray and laboratory tests to the extent that benefits for such services would have been provided if rendered to an in-patient of the hospital;

(4) benefits provided under (1) and (2) of (B) above, may be provided subject to a combined deductible amount not in excess of $250.00.

C. Basic Medical-Surgical Expense Coverage

"Basic Medical-Surgical Expense Coverage" is a Policy of disability insurance which provides coverage for each person insured under the Policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(1) Surgical services

(a) in amounts not less than those provided on a fee schedule based on the relative values contained in the State of New York Certified Surgical Fee Schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale or surgical procedures, up to a maximum of at least $1,600.00 for any one procedure; or

(b) not less than 80% of the reasonable charges.

(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or his assistant) performing the surgical services;

(a) in an amount not less than 80% of the reasonable charges; or

(b) 15% of the surgical service benefit.

(3) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or $25.00 per day for not less than thirty-one (31) days during one period of confinement.

D. Hospital Confinement Indemnity Coverage

"Hospital Confinement Indemnity Coverage" is a Policy of disability insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than $80.00 per day and not less than thirty-one (31) days during any one period of confinement for each person insured under the Policy. No elimination period shall be allowed greater than one (1) day. However, coverage issued as a rider to an existing Policy may be written in an amount not less than $15.00 per day with the same benefit period and elimination period provided in the existing Policy.

E. Major Medical Expense Coverage or Comprehensive Health Expense Coverage

"Major Medical Expense Coverage" or "Comprehensive Health Expense Coverage" is a Policy of disability insurance which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $35,000.00; co-payment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the Policy, unless the Policy is written to compliment underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance that is then in force or thereafter issued, for each covered person for at least;

(1) daily hospital room and board expenses, prior to application of the co-payment percentage for not less than $125.00 daily or the actual semi-private room rate which ever is less for a period of not less than thirty-one (31) days during continuous hospital confinement;

(2) miscellaneous hospital services, prior to application of the co-payment percentage, for an aggregate maximum not less than $5,000.00 or thirty-one (31) times the daily room and board rate if specified in dollar amounts;

(3) surgical services, prior to application of co-payment percentage to a maximum of not less than $1,600.00 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

(4) anesthesia services prior to application of the co-payment percentage, for a maximum of not less than 15% of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

(5) in-hospital medical services, prior to application of the co-payment percentage, as defined in subdivision (C)(3) of Section 7;

(6) out of hospital care, prior to application of the co-payment percentage, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the Policy for diagnosis and

treatment of sickness or injury, and diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(7) not fewer than three of the following additional benefits, prior to application of the co-payment percentage, for an aggregate maximum of such covered charges of not less than $3,200.00:

(a) in-hospital private duty graduate registered nurse services;

(b) convalescent nursing home care;

(c) diagnosis and treatment by a radiologist or physiotherapist;

(d) rental of special medical equipment, as defined by the insurer in the Policy;

(e) artificial limbs or eyes, casts, splints, trusses or braces;

(f) treatment for functional nervous disorders, and mental and emotional disorders; and

(g) out-of-hospital prescription drugs and medications.

F. Disability Income Protection Coverage

"Disability Income Protection Coverage" is a Policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

(1) provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50% of the amounts payable immediately prior to 62.

(2) contains an elimination period no greater than:

(a) Ninety (90) days in the case of a coverage providing a benefit of one (1) year or less;

(b) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years, or

(c) Three hundred sixty-five (365) days in all other cases during the continuance of disability resulting from sickness or injury.

(3) has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a Policy covering disability arising out of normal pregnancy or childbirth in which case the period for such disability may be one (1) month.

No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. Section 7(F) does not apply to those Policies providing business buyout coverage.

G. Accident Only Coverage and Specified Accident Coverage

(1) "Accident Only Coverage" is a Policy of disability insurance which provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least $1,000,00 and a single dismemberment amount shall be at least $500.00.

(2) "Specified Accident Coverage" is an accident insurance Policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the Policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than $1,000.00 for accidental death, $1,000.00 for double dismemberment and $500.00 for a single dismemberment.

H. Specified Disease Coverage

(1) Specified Disease Coverage - See Appendix

(2) Cancer Coverage - See Appendix

I. Nursing Home Confinement Indemnity Coverage

"Nursing Home Confinement Indemnity Coverage" is a Policy of disability insurance which provides benefits for confinement in facilities as defined in Section 5(C) of this rule on a daily indemnity basis. Benefits may not be more restrictive than the following:

(a) $45.00 per day from the first day;

(b) benefit period not less than 365 days; and

(c) requirement that insured be hospitalized for at least three (3) days and enter the facility within fourteen (14) days following hospital discharge.

J. Intensive Care Unit Indemnity Coverage

"Intensive Care Unit Indemnity Coverage" is a Policy of disability insurance which provides daily benefits for hospital confinement in an intensive care unit on an indemnity basis in an amount not less than $150.00 per day and not less than fifteen (15) days during any one period of confinement for each person insured under the Policy. No elimination period shall be allowed.

A definition of Hospital Intensive Care Unit shall not be more restrictive than the following: Specifically designated facility of the hospital that provides the highest level of medical care and which is restricted to those patients who are physically, critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement.

They must be permanently equipped with special equipment for the care of the critically ill or injured, and they must be under close observation by trained and qualified personnel assigned on a full-time basis, exclusively to that unit.

K. Limited Benefit Health Insurance Coverage

"Limited Benefit Health Insurance Coverage" is any Policy or contract which provides benefits that are less than the minimum standards for benefits required under Section 7(B), (C), (D), (E), (F), (G), (H), (I), (J) and Appendix (B), (C) and (D). Such Policies or contracts may be delivered or issued for delivery in this State only if the outline of coverage required by Section 8(J) of this rule is completed and delivered by Section 8(B) of this rule. The Policy title required by Section 7(A)(1) shall include "Limited Benefit Health Insurance Coverage" as well as the appropriate categories of coverage.

Section 8. Required Disclosure Provisions

A. General Rules

(1) Each Policy shall include a renewal, continuation, or nonrewal provision. The language or specification of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned and clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the Policy is issued and for which it may be renewed.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the Policy, all riders or endorsements added to a Policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the Policy shall require signed acceptance by the policyholder. After date of Policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the Policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law.

(3) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the Policy.

(4) A Policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(5) If a Policy contains any limitations with respect to pre-existing conditions, such limitations must appear as a separate paragraph of the Policy and be labeled as "Pre-existing Condition Limitations".

(6) All accident only Policies and specified disease Policies and specified accident Policies shall contain a prominent statement on the first page of the Policy or attached thereto in either contrasting color or in boldface type at least equal to the size of type used for Policy captions, a prominent statement as follows:

"This is an (include appropriate Policy title) only Policy and it does not pay benefits for loss from any other cause.

(7) All Policies, except single premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the Policy or attached thereto, stating in substance that the policyholder shall have the right to return the Policy within ten (10) days of its delivery unless the Policy provides for a greater period, and to have the premium refunded if, after examination of the Policy, the policyholder is not satisfied for any reason. With respect to Policies issued pursuant to a direct response solicitation to persons eligible for Medicare by reason of age, the Policy shall have a notice prominently printed on the first page of the Policy or attached thereto stating in substance that the policyholder shall have the right to return the Policy within thirty (30) days of its delivery and to have the premium refunded if after examination of the Policy, the policyholder is not satisfied for any reason.

(8) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the Policy as originally issued, such fact must be prominently set forth in the outline of coverage.

(9) If a Policy contains a conversion privilege, it shall comply, in substance, with the following: the caption of the provision shall be "Conversion Privilege", or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a Policy form then being used by the insurer for that purpose.

(10) Insurers issuing Policies which provide hospital or medical expense coverage on an expense incurred or indemnity basis other than incidentally, to a person(s) eligible for Medicare by reason of age, shall provide to the policyholder, a Medicare Supplement buyer's guide as described in Rule and Regulation'27. Delivery of the buyer's guide shall be made whether or not such individual Policy qualifies as a Medicare Supplement Policy as defined in Rule and Regulation 27. Except in the case of direct response insurers, delivery of the buyer's guide shall be made at the time of application and acknowledgment of receipt of certification of delivery of the buyer's

guide shall be provided to the insurer. Direct response insurers shall deliver the buyer's guide not later than the time the Policy is delivered, or sooner upon request. The phrase "other than incidentally" is intended to exempt Policies such as those which provide accidental death benefits for travel or other accidents and where the medical expense or indemnity, if any, only accompanies such other benefits.

(11) Outlines of coverage delivered in connection with Policies defined in this rule as "Hospital Confinement Indemnity", "Specified Disease", "Nursing Home Confinement Indemnity Coverage", "Intensive Care Unit Indemnity Coverage", or "Limited Benefit Health Insurance Coverage" to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Sections 8(F), 8(1) and Rule and Regulation 27, the following language which shall be printed on or attached to the first page of the outline of coverage:

This policy IS NOT A MEDICARE SUPPLEMENT POLICY.

(12) All specified disease and cancer Policies shall contain a prominent statement on the first page of the Policy or attached thereto in either contrasting color or in boldface type at least equal to the size of type for Policy captions, a prominent statement as follows:

CAUTION: This is a limited policy. Read it carefully with the outline of coverage.

B. Outline of Coverage Requirements for Individual Coverages

No Policies subject to this rule shall be delivered or issued for delivery in this State unless an appropriate outline of coverage, as prescribed in Section 8(C) through (J) is completed as to Policy or contract and, the outline is either delivered with the Policy or delivered to the applicant at the time the application is made and acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insurer.

If an outline of coverage was delivered at the time of application and the Policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the Policy or contract must accompany the Policy or contract when it is delivered and contain the following a statement, in no less than ten (10) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

The appropriate outline of coverage for Policies or contracts providing hospital coverage which only meet the standards of Section 7(B) shall be that statement contained in Section 8(C). The appropriate outline of coverage for Policies or contracts providing coverage which meet the standards of both Sections 7(B) and (C) shall be the statement contained in Section 8(E). The appropriate outline of coverage for Policies or contracts providing coverage which meet the standards of both Sections 7(B) and (E) or Section 7(C) and (E) or Section 7(B), (C), and (E) shall be the statement contained in Section 8(G). The appropriate outline of coverage for Policies or contracts providing coverage which meet the standards of either 7(D), 7(1), or 70) shall be the statement contained in Section 8(F). The appropriate outline of coverage for Policies or contracts providing coverage which meet the standards of Sections 7(G), or 7(H) shall be the statement contained in Section 8(1). The appropriate outline of coverage for Policies or contracts providing coverage which meet the standards of Section 7(F), shall be the statement contained in Section 8(H). The appropriate outline of coverage for Policies or contracts providing coverage which meet the standards of Section 7(K) shall be the statement contained in Section 8(J).

Appropriate changes in terminology may be made in the outline of coverage in the case of a Policy or Policies. In any other case where the prescribed outline of coverage is inappropriate for the coverage provided by the Policy or contract, an alternate outline of coverage shall be submitted to the Commissioner for prior approval.

C. Basic Hospital Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with Policies meeting the standards of Section 7(B) of this rule. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

BASIC HOSPITAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY,

(2) Basic Hospital Expense Coverage - Policies of this category are designed to provide to persons insured coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital out-patient services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

(3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this Policy, in the following order:

(a) daily hospital room and board;
(b) miscellaneous hospital services;
(c) hospital out-patient services; and
(d) other benefits, if any.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any Policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of Policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

D. Basic Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with ' Policies meeting the standards of Section 7(C) of this rule. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. it is, therefore, important that you READ YOUR POLICY CAREFULLY'

(2) Basic Medical-Surgical Expense Coverage - Policies of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.

(3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this Policy, in the following order:

(a) surgical services;

(b) anesthesia services;

(c) in-hospital medical services; and

(d) other benefits, if any.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any Policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of Policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

E. Basic Hospital and Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with Policies meeting the standards of Section 7(B) and (C) of this rule. The items included in the outline of coverage must appear in the sequence prescribed.

(COMPANY NAME)

BASIC HOSPITAL AND MEDICAL-SURGICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) Basic Hospital and Medical-Surgical Expense Coverage - Policies of this category are signed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital out-patient services, surgical services, anesthesia services, and in-hospital medical services, su1bject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses.

(3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this Policy, in the following order:

(a) daily hospital room and board;

(b) miscellaneous hospital services;

(c) hospital out-patient services;

(d) surgical services;

(e) anesthesia services;

(f) in-hospital medical services; and

(g) other benefits, if any.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any Policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of Policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

F. Hospital Confinement Indemnity Coverage or Nursing Home Confinement Indemnity Coverage or Intensive Care Unit, Indemnity Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with Policies meeting the standards of Section 7(D) or 7(I) or 7(J) of this rule. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

[HOSPITAL CONFINEMENT INDEMNITY],

[NURSING HOME CONFINEMENT INDEMNITY],

OR [INTENSIVE CARE UNIT INDEMNITY] COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY'

(2) Hospital Confinement Indemnity Coverage (or Nursing Home Confinement Indemnity or Intensive Care Unit Indemnity Coverage - Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization (nursing home confinement or intensive care) resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement (nursing home confinement or intensive care) and any additional benefit described below.

(3) (A brief specific description of the benefits contained in this Policy, in the following order:

(a) daily benefit payable during (hospital, nursing or intensive care unit] confinement; and

(b) duration of benefit described in (a).)

(Note: The above description of benefits shall be stated clearly and concisely.)

(4) (A description of any Policy provisions which exclude, eliminate restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefit, described in (3) above.)
(
(5) (A description of Policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(6) (Any benefits provided in addition to the daily [hospital, nursing home or intensive care unit] benefit.)

G. Major Medical Expense Coverage or Comprehensive Health Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with Policies meeting the standards of Section 7(E) of this rule. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

MAJOR MEDICAL EXPENSE COVERAGE

OR [COMPREHENSIVE HEALTH EXPENSE COVERAGE]

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY'

(2) Major Medical Expense Coverage or [Comprehensive Health Expense Coverage] - Policies of this category are designed to provide to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(3) (A brief specific description of the benefits, including dollar amounts, contained in this Policy in the following order:

(a) daily hospital room and board;

(b) miscellaneous hospital services;

(c) surgical services;

(d) anesthesia services;

(e) in-hospital medical services;

(f) out of hospital care;

(g) maximum dollar amount for covered charges; and

(h) other benefits, if any.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any Policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of Policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

H. Disability Income Protection Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with Policies meeting the standards of Section 7(F) of this rule. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

DISABILITY INCOME PROTECTION COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY'

(2) Disability Income Protection Coverage - Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) (A brief specific description of the benefit contained in this Policy.)

(Note: The above description of benefits shall be stated clearly and concisely.)

(4) (A description of any Policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of Policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

I. Accident Only Coverage, Specified Accident Coverage or Specified Disease Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below, shall be issued in connection with Policies meeting the standards of Section 7(G) of this rule. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

[ACCIDENT ONLY], [SPECIFIED ACCIDENT],

OR [SPECIFIED DISEASE] COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) (Accident Only), (Specified Accident), or (Specified Disease) Coverage - Policies of this category are designed to provide to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of (accident only), (specified accident) or (specified disease). Coverage is not provided for basic hospital, basic medical-surgical, or major medical or comprehensive expenses.

(3) (A brief specific description of the benefits, including dollar amounts, contained in this Policy.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (A)(13) of Section 7 of this rule.

(4) (A description of any Policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of Policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

J. Limited Benefit Health Insurance Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with Policies which do not meet the minimum standards of Sectors 7(B), (C), (D), (E), (G), (H), (I) and (J) of this rule. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

LIMITED BENEFIT HEALTH COVERAGE

(APPROPRIATE CATEGORY OF COVERAGE)

OUTLINE OF COVERAGE

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR POLICY CAREFULLY'

(2) Limited Benefit Health Coverage - Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

(3) (A brief specific description of the benefits, including dollar amounts, contained in this Policy:)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (A)(13) of Section 7 of this rule.)

(4) (A description of any Policy provision which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operates to qualify payment of the benefits described in (3) above.)

(5) (A description of Policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

Section 9.Requirements for Replacement

A. Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other disability insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

B. Upon determining that a sale will involve replacement an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the Policy, the notice described in (C) below. One (1) copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the Policy, the notice described in (D) below. In no event, however, will such a notice be required in the solicitation of the following types of Policies: accident only and single premium nonrenewable Policies.

C. The notice required by (B) above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF DISABILITY INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing disability insurance and replace it with a policy to be issued by (insert company name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____
(Applicant's Signature)

D. The notice required by (B) above for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF DISABILITY INSURANCE

According to (your application) (information you have furnished),you intend to lapse or otherwise terminate existing disability insurance and replace it with the policy delivered herewith issued by (insert company name) Insurance Company. Your new policy provides ten (10) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) (To be included only if the application is attached to the Policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert company name and address) within ten (10) days if any information is not correct and complete, or if any past medical history has been left out of the application.

Section 10. Severability

Any section or provision of this rule held by a court to be invalid or unconstitutional will not affect the validity of any other section or provision.

APPENDIX

Specified Disease

1. "Specified Disease Coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Any such policy must meet the following general rules and one of the following sets of minimum standards for benefits; such insurance covering cancer - whether cancer only or in conjunction with other conditions(s) or disease(s) - must meet the standards of subsection (C) or (D); insurance covering specific disease(s) other than cancer must meet the standards of subsection (B).

A. General Rules.

The following rules shall apply to specified disease coverages in addition to all other rules imposed by this rule; in cases of conflict between the following and other rules, the following ones shall govern:

(1) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this Section.

(2) Any Policy issued pursuant to this Section which conditions payment upon pathological diagnosis of a covered disease, shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof.

(3) Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other condition(s) or disease(s), directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).

(4) Policies containing specified disease coverage shall be at least Guaranteed Renewable.

(5) No Policy issued pursuant to this Section shall contain a waiting or probationary period greater than thirty (30) days.

(6) Any application for specified disease coverage shall contain a statement above the signature of the applicant that no person to be covered for specified disease is also covered by any Title XIX program (Medicaid or any similar name). Such statement may be combined with any other statement for which the insurer may require the applicant's signature.

(7) Payments may be conditioned upon a covered person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

(8) Except for the uniform provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage available through individual health insurance.

(9) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if such care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of such coverage may not be less than ninety (90) days prior to such diagnosis.

B. The following minimum benefit standards apply to non-cancer coverages, one of the following standards must be met:

(1) A Policy which provides coverage for each person insured under the Policy for a specifically named disease (or diseases) with a deductible amount not in excess of $250.00 and an overall aggregate

benefit limit of no less than $10,000.00 and a benefit period of not less than three (3) years for at least the following incurred expenses.

(a) Hospital room and board and any other hospital furnished medical services or supplies;

(b) Treatment by a legally qualified physician or surgeon;

(c) Private duty services of a registered nurse (R.N.);

(d) X-ray, radium and other therapy procedures used in diagnosis and treatment;

(e) Professional ambulance for local service to or from a local hospital;

(f) Blood transfusions, including expense incurred for blood donors;

(g) Drugs and medicines prescribed by a physician;

(h) The rental of an iron lung or similar mechanical apparatus;

(i) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;

(j) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

(k) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(2) A Policy which provides coverage for each person insured under the Policy for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than $50,000.00 payable at the rate of not less than $100.00 a day while confined in a hospital and a benefit period of not less than 500 days.

C. A Policy which provides coverage for each person insured under the Policy for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment that are ordered or prescribed by a physician as necessary for the treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of $250.00, and an overall aggregate benefit limit of not less than $10,000.00 and a benefit period of not less than three (3) years for at least the following:

(1) Treatment by, or under the direction of, a legally qualified physician or surgeon;

(2) X-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment;'

(3) Hospital room and board and any other hospital furnished medical services or supplies;

(4) Blood transfusions, and the administration thereof, including expense incurred for blood donors;

(5) Drugs and medicines prescribed by a physician;

(6) Professional ambulance for local service to or from a local hospital;

(7) Private duty services of a registered nurse (R.N.) provided in a hospital; and

(8) May include coverage of any other expenses necessarily incurred in the treatment of the disease. Provided, however, if such other expenses are covered, that Items (1), (2), (4), (5) and (7) plus at least the following shall be included, but may be subject to co-payment by the covered person not to exceed 20% of covered charges, when rendered on an out-patient basis.

(a) Braces, crutches, and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;

(b) Emergency transportation if in the opinion Of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

(c) Home health care, that is necessary care and treatment provided at the covered person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment must be prescribed in writing by the covered person's attending physician, who must approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required.

(For definition of Home Health Care Agency, see Section 2 of this Appendix.)

(d) Physical, speech, hearing and occupational therapy,

(e) Special equipment including hospital bed toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;

(f) Prosthetic devices including wigs and artificial breasts;

(g) Nursing home care for non-custodial services.

(9) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

D. The following minimum benefit standards apply to cancer coverages written on a per them indemnity basis. Such coverages must offer covered persons:

(1) A fixed-sum payment of at least $150.00 for each day of hospital confinement for at least 365 days.

(2) A fixed-sum payment equal to one half the hospital in-patient benefit for each day of hospital or non-hospital out-patient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment.

Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional; if a Policy offers these benefits, they must equal the following:

(3) A fixed-sum payment equal to one forth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.

(4) A fixed-sum payment equal to one forth the hospital in-patient benefit for each day of home health care for at least 100 days.

(5) Notwithstanding any other provision of this rule any restriction or limitation applied to the benefits in (D)(3) and (D)(4), above, whether by definition or otherwise, shall be no more restrictive than those under Medicare.

2. Home Health Care Agency

A. A Home Health Care Agency is one which:

(1) is an agency approved under Title XVIII of the Social Security Act (Medicare), or

(2) is licensed to provide home health care under applicable state law, or

(3) meets all of the following requirements:

(a) It is primarily engaged in providing home health care services;

(b) Its policies are established by a group of professional personnel [including at least one physician and one registered nurse (R.N.)];

(c) Supervision of home health care services is provided by a physician or a registered nurse (R.N.);

(d) It maintains clinical records on all patients; and

(e) It has a full time administrator.

B. Home Health Care includes, but is not limited to:

(1) part time or intermittent skilled nursing services provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.);

(2) part time or intermittent home health aid services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapist;

(3) physical, occupational or speech and hearing therapy; and

(4) medical supplies, drugs, and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the policy if the insured person had remained in the hospital.

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Robert M. Eubanks III
Insurance Commissioner

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July 20,1977
Date